

PATIENT INFORMED CONSENT FORM

For Secret RF Treatment

I hereby authorize Dr. _____ or _____, under Dr. _____'s supervision to perform the Secret RF radiofrequency microneedling treatment. Secret RF's microneedles smoothly penetrate the skin, delivering energy at various depths in the epidermis and dermis to induce collagen regeneration while sparing the skin's surface. Secret RF can be used to improve your skin quality by reducing signs of photo aging and photo damage, fine lines and wrinkles, stretchmarks and scars/acne scars. It may take multiple treatments to obtain optimal results, and it is possible that the results will be minimal or not help at all. The results may be temporary or permanent and there is no way to predict how long the results will last. Although these devices are effective in most cases, no guarantees can be made.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN** – Some discomfort and/ or pain may be experienced during treatment. A topical anesthetic will be applied to your skin before treatment. Other forms of anesthesia, or pain management, may also be used.
- **SWELLING** – Swelling (edema) of the treated area is common and may occur. This usually resolves in a few days.
- **REDNESS** – Redness (erythema) of the treated area is common and may occur. The erythema typically resolves in about two weeks.
- **SKIN COLOR CHANGES** – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent. You should avoid sun exposure after the treatment and use sunblock.
- **MILIA/ACNE** – Ointments that occlude hair follicles, sweat ducts, or sebaceous ducts may lead to milia/acne formation. This is more common in patients with a history of cystic acne or oily skin.
- **WOUNDS** – Treatment can result in burning, blistering, or bleeding of the treated areas. It is important that you not pick or scratch the sites as this may lead to permanent scars or promote an infection. If any of these occur, please call our office.
- **INFECTION** – Infection is a possibility whenever the skin surface is disrupted which can lead to scarring. Proper wound care and keeping the treated area clean are important. If signs of infection develop, such as pain, heat, blisters, or surrounding redness, please call our office 509-540-5014.
- **CONTACT/ALLERGIC DERMATITIS OR SKIN SENSITIVITY** – Potential increased sensitivity, irritation/itching or allergic reaction of the skin due to skin surface disruption.
- **SCARRING** – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- **TREATMENT PATTERN** – A persistent spot size pattern may be apparent on the treated skin and usually resolves with time. In rare cases, it may be permanent.
- **PETECHIAE** – May appear for several weeks after healing and clear without treatment.
- **DILATED PORES** – Collagen contraction that occurs as part of the resurfacing process may also contract the skin between the pores, which widens the existing pores. This occurrence, though rare, is permanent.
- **SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING** – May increase risk of side effects and adverse events.
- **ALLERGY** – There is a risk of an allergic reaction to the topical anesthetic.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. _____ and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do do not authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE SECRET RF TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient

Print Name

Date

Signature-Witness

Print Name

Date